February 12, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0560-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopaedic Surgery The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 34-year-old mobile home salesman who fell coming out of a mobile home at work and sustained a lower back injury and a left ankle fracture. The ankle fracture was treated with casting and it did not heal. He subsequently required an open reduction, internal fixation on the ankle fracture on 9/28/01. This time the fracture haled after the procedure was done. The present dispute is regarding treatment for his back injury. The patient has had lower back and leg symptoms consistent with some degree of radiculopathy. He has been well worked up with multiple x-rays, MRI studies and also a lumbar discogram. He has been found to have a disc herniation at L5/S1, 3 mm in size. He has also been found to have facet hypertrophy and facet arthritis at the L5/S1 level on plain films of his back. He also has 50% narrowing of the disc space at L5/S1 on the plain films of his back.

On 3/26/02, the patient had a lumbar discogram that demonstrated concordant pain at theL5/S1 level. The patient has been treated and evaluated by ___. He has suggested anterior discectomy with posterior decompression and a posterior fusion and instrumentation. This procedure has not been approved by the insurance carrier. The patient has had a series of lumbar epidural steroid injections from ___. These did not give him any relief of symptoms. He has had considerable pain medication and has gone through a pain management program and is still not able to return to work and has not received any relief of pain in his back. He is now nearly two years since the date of injury and his present doctor, who is ___, has recommended the above surgical fusion and posterior decompression with disc removal.

REQUESTED SERVICE

Anterior lumbar discectomy and posterior lumbar interbody fusion with pedicle screws at L5/S1 is requested for this ___.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that this patient represents a case of failed conservative treatment. His plain x-rays done on March 26, 2002 demonstrate facet arthritis at the L5/S1 level with 50% narrowing of the disc at that level. His discogram demonstrated concordant pain in the L5/S1 joint in his back. He did not get any relief from the epidural steroid injections; therefore, the reviewer finds that he is a candidate for lumbar discectomy with posterior decompression and fusion of the L5/S1 joint as suggested by ___. Fusion is indicated because of the result of the provocative discogram and the facet arthritis that has been reported to be present at the L5/S1 level.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 12th day of February, 2003.